

Materials used to support Cognitive Behavioural Therapy for depression: a survey of therapists' clinical practice and views

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Materials used to support Cognitive Behavioural Therapy for depression: a survey of therapists' clinical practice and views

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Materials used to support Cognitive Behavioural Therapy for depression: a survey of therapists' clinical practice and views

Use of supporting materials in cognitive behavioural therapy (CBT) is widely advocated, and homework increases effectiveness. The study aimed to identify materials most frequently used by CBT therapists to support CBT for depression, and those perceived most clinically effective. Questionnaires were sent to 3665 accredited CBT therapists asking about their use of resources commonly described in CBT manuals, and their views on effectiveness. Of 3665 approached by post/email, 994 (27%) responded. Another 33 completed the questionnaire via the study website. 818/1027 (80%) of respondents were accredited practitioners who deliver one-to-one therapy. Symptom measures, lists of problems/goals, activity schedules, behavioural activation diaries/plans, and case formulation worksheets were used "frequently" or "very frequently" by over 85% of respondents. Sleep diaries and computerised CBT were used least. Most resources were used within and between sessions. Activity schedules, behavioural activation diaries/plans, case formulation worksheets, thought records, and resources to support identification of conditional beliefs were regarded as most effective. Symptom measures, sleep diaries and computerised/online materials were considered only moderately effective. Therapists use a wide range of materials to support individual CBT. Technology-enabled approaches to delivering CBT should incorporate a range of materials to enable therapists to tailor treatment effectively.

Keywords: cognitive behavioural therapy; individual CBT; depression; treatment components; attitudes; clinical practice

Introduction

Cognitive behavioural therapy (CBT) is an effective treatment for depression (A. Butler, Chapman, Forman, & Beck, 2006). It is an educational approach and evidence suggests that patients' development and use of cognitive therapy skills predict reduced risk for relapse (Strunk, DeRubeis, Chiu & Alvarez, 2007). As such, between session tasks ('homework') that allow patients to practise skills learnt during sessions with their therapist are an integral part of therapy (J. Beck, 2011). There is evidence that completion of homework outside of the therapy session is associated with better outcomes (Kazantzis, Whittington, & Dattilio, 2010; Mausbach, Moore, Roesch, Cardenas, & Patterson, 2010; Thase & Callan, 2006). Introducing resources such as worksheets and psychoeducational materials to the patient during the therapy session may facilitate completion of such tasks. However, little is known about the resources that therapists use, both between and within sessions, to support one-to-one CBT for depression.

Previous UK postal surveys of practitioners accredited by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) (Keeley, Williams, & Shapiro, 2002; MacLeod, Martinez, & Williams, 2008) have focussed on the use of self-help materials and found that most therapists regularly recommended self-help approaches, largely written CBT materials. Therapists viewed these resources as particularly important for increasing client's understanding of their mental health problems, their sense of control and motivation, for preventing relapse, and reducing the length of time required with a therapist (Keeley et al.). Whilst these self-help materials were viewed positively, they were mainly used as an adjunct to individual therapy rather than as an integral part of CBT (MacLeod et al., 2008).

Advances in technology makes it possible to integrate individual, one-to-one CBT (delivered online and/or face-to-face) with linked online elements such as homework tasks. Enabling discrete completion of homework tasks (e.g. through apps or use of mobile devices)

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3 may help remove some of the barriers to completion of homework, for example the risk of
4 getting ‘caught’ writing down thoughts and feelings on paper; or having to wait until the
5 evening to recall earlier thoughts for homework tasks (Barnes, et al., 2013). Moreover,
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7
8 previous research (Barnes, et al., 2013) has highlighted that clients report difficulties
9
10 attending face-to-face sessions because of other commitments, caring responsibilities and
11
12 inconvenient appointment times and/or locations. Such issues were common reasons for
13
14 depressed clients not starting, or for withdrawing from therapy (Barnes, et al., 2013). Thus,
15
16 the development of “technology-enabled” services (Mohr, Weingart, Reddy, & Schueller,
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18 2017) has the potential to improve access to, and engagement with, therapy and hence
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20 improve patient outcomes. However, in order to develop such services, we need to
21
22 understand more about the resources that are used by therapists providing CBT for people
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24 with depression and how effective therapists regard these in improving outcomes for patients.
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31 Collections of online resources which include CBT worksheets and
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33 psychoeducational resources are available for therapists to access and use as part of therapy.
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35 Examples include GetSelfHelp (<https://www.getselfhelp.co.uk/>), Psychology Tools
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37 (<https://www.psychologytools.com/>) and the Centre for Clinical Interventions
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39 (<https://www.cci.health.wa.gov.au/Resources/For-Clinicians>). However, the use of supporting
40
41 materials is not routinely reported in clinical trials of CBT. Furthermore, there is currently no
42
43 empirical evidence on which resources therapists use in their day-to-day practice with clients
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45 with depression, how they use these tools, or how effective they consider them to be.
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50 Therefore, the aim of our study was to identify materials that are commonly used by
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52 CBT therapists to support one-to-one CBT with patients who have depression, and to identify
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54 the materials therapists perceive as most effective in bringing about clinically helpful change.
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Methods

Design

This cross-sectional questionnaire study is part of a six-year programme of work funded by [funding reference number anonymised] to develop and evaluate a new intervention for depression that will integrate one-to-one CBT sessions with a therapist (initial appointment face-to-face and subsequently online), with online CBT materials. The intervention will be delivered via a purpose-built, online platform which will include a wide range of high-quality online resources for patients to access as part of their therapy, and functionality to enable therapy sessions to take place remotely.

Participants

We aimed to survey accredited CBT practitioners in order to inform the development of the online CBT resources. The British Association for Behavioural and Cognitive Psychotherapies (BABCP: <http://www.babcp.com/>) is the lead body for CBT therapists in the UK. The National Health Service (NHS) has invested in Improving Access to Psychological Therapies (IAPT) services to improve access to psychological therapist for patients in England. CBT therapists working within the NHS IAPT services are required to be accredited by BABCP if they deliver ‘high-intensity’ (one-to-one) therapy. We aimed to specifically target accredited CBT practitioners across the UK and Ireland who deliver ‘high-intensity’ therapy as this represented the group of practitioners who would deliver our new intervention. Respondents were excluded if they were not BABCP accredited, or not working as a ‘high-intensity’ practitioner.

Procedure

We used three recruitment strategies in order to maximise the number of accredited ‘high-intensity’ CBT practitioners invited:

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3 (1) *Recruitment via BABCP membership list*
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5 When CBT therapists apply to become a member of the BABCP, they are asked whether their
6 contact details can be passed on to other organisations – for example, those conducting
7 research surveys relating to CBT. At the time of the survey, the BABCP had approximately
8 4600 accredited practitioners, supervisors and trainers. Of these, 3665 had consented for their
9 contact details to be used in this way. 2528 (69%) had agreed to be contacted either by post
10 or email, 28 (1%) by post only, and 1109 (31%) by email only.
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19 *Invitations by post.* Questionnaires were mailed out in April 2016, to the 2556 individuals
20 who had consented to being contacted by post, along with a participant information leaflet
21 about the study and a reply-paid envelope. A covering letter also included details of a web-
22 link for therapists to complete the questionnaire online if they preferred. Completion of the
23 questionnaire was taken as consent to participate. Therapists were given the option of
24 returning the questionnaire blank if they did not want to participate. A reminder letter was
25 sent to non-responders approximately 2 weeks after the initial mail out, and a final reminder
26 sent to non-responders after a further 2 weeks.
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37 *Invitations by email.* Therapists who agreed to being contacted by email only (n=1109) were
38 emailed in April 2016, with an invitation to participate. The email included a web-link to the
39 participant information leaflet, and to the online survey. Therapists were given the option of
40 contacting the research team if they did not want to participate. A reminder email was sent to
41 non-responders 2 weeks after the initial mail out, and a final reminder was sent after a further
42 2 weeks. All respondents were entered into a draw to win one of ten £25 gift vouchers as a
43 sign of appreciation for completing the survey.
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3 *(2) Recruitment of IAPT high-intensity CBT therapists via service/clinical leads*
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5 Whilst the BABCP membership list enabled us to contact approximately three quarters of
6 accredited CBT practitioners, we wanted to survey all accredited practitioners and therefore
7 used an alternative route to promote the survey in an attempt to capture views from the wider
8 body of practitioners who had opted out of the BABCP mailing list. Thus, we emailed IAPT
9 service/clinical leads to ask for their support in encouraging their high-intensity (specialist)
10 CBT therapists within their service to complete the survey online. We provided
11 service/clinical leads with a web-link directing them to the information leaflet and online
12 questionnaire. One reminder email was sent to service leads two weeks later.
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24 *(3) Promotion of the survey through the BABCP member magazine and Practitioner*
25 *workshops/meetings*
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28 To further encourage participation, a brief article was published in the BABCP member
29 magazine (CBT Today) in April 2016 to promote the survey. The article outlined the research
30 planned within the *[name of research programme anonymised]*, including the survey.
31 Contact details of the research team, and a web-link to the information leaflet and online
32 survey were included. The survey was also promoted during presentations at the BABCP
33 conferences in April and June 2016, and via the BABCP Twitter feed in May 2016. A web-
34 link to the online survey was included in these promotions.
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46 *Therapists' questionnaire*
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48 Therapists were asked to provide brief demographic details, and details about their
49 professional background and experience. Therapists were then asked about the materials they
50 used to supplement one-to-one CBT for depression. The materials we listed in the
51 questionnaire were based on those recommended in CBT for depression treatment manuals or
52 that would support key CBT techniques. These were:
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- Symptom measures such as the Beck Depression Inventory and PHQ-9

- Providing a list of problems and goals
- Resources to support practical problem solving (e.g. a problem list)
- Creating a written agenda
- Activity schedules
- Behavioural activation diary or plan
- Written resources to support planned exposure
- Written resources to support behavioural experiments relating to depressive beliefs
- Mood diary
- Thought record (could include the use of ‘critical voice’/‘self-esteem’ thought record)
- Written/diagrammatic resources to support identification of unhelpful thinking.
- Case formulation/ case conceptualisation worksheet
- Written/diagrammatic resources to support identification of conditional beliefs / underlying assumptions / ‘rules for living’
- Relaxation materials (written resources or tapes)
- Sleep diary (which relates sleep to mood and activities)
- Books/workbooks (e.g. Mind over Mood, ‘Five Areas Approach’)
- Computerised CBT and online materials (e.g. “Beating the Blues” or “MoodGYM”)

The therapists were asked to think about their last three clients with depression, and to indicate how often they used the above materials, and whether the materials were given to clients for use between, or during, the CBT sessions. (We did not give specific citations for these materials in our questionnaire, but interested readers can find examples of many of these resources on websites such “Get Self Help” (<https://www.getselfhelp.co.uk>), “Centre

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3 for Clinical Interventions” (<http://www.cci.health.wa.gov.au>), and “Psychology Tools”
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5 (<https://psychologytools.com>).
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8 Therapists were also asked to list any books, computerised CBT, online or other
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10 materials they used to supplement one-to-one work with their last three clients with
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12 depression.
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15 Finally, therapists were asked about their wider experience of using materials to
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17 support one-to-one CBT for depression, and to indicate how effective each of the listed
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19 materials were in bringing about clinically helpful change, on a scale of 1 (not at all
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21 effective), to 9 (very effective).
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24 *Data Analysis*

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26 Descriptive statistics were used to summarise the information provided by therapists
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28 regarding the resources/materials and techniques used to support CBT in terms of the
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30 frequency of use of such resources/techniques, whether used within/between sessions and
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32 their views on the effectiveness of the various resources.
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36 In order to investigate the association between therapist characteristics (gender, age,
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38 professional background, years practicing as a CBT therapist, IAPT work, supervisor work,
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40 work setting) and frequency of use of the 17 resources/techniques, due to sparse data it was
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42 necessary to recode frequency into a binary variable (never/rarely/sometimes vs.
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44 frequently/very frequently). Subsequently, logistic regression was used to develop a
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46 parsimonious model to examine the associations of interest. Therapist characteristics were
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48 operationalised as listed in Table 1, with the exception of professional background which was
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50 collapsed into 11 groups due to sparse data. All seven therapist characteristics were included
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52 in the initial multivariable model which was simplified using the likelihood ratio test. All
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54 variables at a level of $p < 0.10$ were retained.
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3 Exploratory analyses were also undertaken to examine the association between
4 therapist characteristics and ratings of effectiveness. Therapist characteristics were
5 operationalised as listed in Table 1. Linear regression models (with effectiveness as a
6 continuous outcome) were developed using the same process as outlined above.
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12 Text responses to the question: 'Please list the books and/or the computerised
13 CBT/online materials that you used to supplement your one-to-one work with your last 3
14 clients with depression' were categorised using an iterative framework approach. First, the
15 data were reviewed by one researcher (C-AM) to identify the most commonly cited,
16 identifiable resources (for example, a specific, named website or book such as the Get Self
17 Help website) and early categories for these data were defined. A second researcher (DT)
18 then reviewed each therapist's response in detail, and coded it against these existing specific
19 resource categories where possible. Further coding categories were added if more than one
20 person had cited a specific resource, and existing coding was refined as the iterative analysis
21 process continued. For example, broader categories which encompassed a number of related
22 book titles were later sub-divided into more specific categories where a number of the
23 respondents had named a particular book title. Where people had listed generic approaches
24 such as 'mindfulness' or 'Acceptance and Commitment Therapy' (rather than identifying a
25 specific resource), these were coded according to these themes. For example, responses
26 which included 'mindfulness' without reference to a particular book or website were
27 categorised as 'mindfulness not otherwise specified'. Most of the text data could be
28 categorised, and descriptive statistics were used to summarise the data. A third author (NW)
29 reviewed a random sample of 10% of the responses and found only one coding discrepancy,
30 which was resolved through discussion.
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55 Sensitivity analyses were conducted to explore the impact of bias due to non-
56 response. We compared the gender balance of survey respondents with the gender data from
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3 the full list of invitees. As further background data were not available for non-responders, we
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5 hypothesised that those who responded to later invites may be more similar to non-responders
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7 and therefore compared the frequency of use of resources for those who responded to the
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9 initial invite with responses for those who responded to reminders. We also compared the use
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11 of, and views on the effectiveness of, materials to support CBT between those who responded
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13 to the initial invite and subsequent reminders. These analyses included people who were
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15 invited by post and those invited by email.
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20 **Results**

21 *Participants*

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23 In total, 3665 accredited BABCP therapists were sent a personally-addressed invitation to
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25 take part. Of these, 858/2556 (33.6%) responded to the postal invitation, and 136/1109
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27 (12.3%) responded to the email invitation (Figure 1). Thus, the overall response to the
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29 email/postal invitations was 27%. A further 33 respondents accessed the survey directly via
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31 the study website. Of the 1027 responses received, 209 were excluded as the therapist was
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33 not BABCP accredited, and/or was not working as a high-intensity practitioner. Of those
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35 excluded, 177 had not provided data on whether they were accredited, or working as a
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37 high/low-intensity practitioner. Thus, data provided by 818 high-intensity BABCP accredited
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39 therapists were included in the analysis.
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46 **[INSERT FIGURE 1 HERE]**

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49 Characteristics of the respondents are presented in Table 1. The majority of survey
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51 participants were female (n = 618, 76%). This was similar to the proportion listed in original
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53 BABCP mailing list (where gender could be derived from members' titles), 2283/3043 (75%)
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55 were female.
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3 The mean age was 46.9 years. Respondents came from a variety of professional
4 backgrounds. Most worked exclusively within the NHS (58%); 27% in both the NHS and
5 private practice. A minority (15%) worked only in private practice. The median length of
6 time practising as a CBT therapist was 7 years [IQR 5, 12]. The majority of therapists (70%)
7 worked as supervisors and within IAPT services (62%).
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15 Therapists working in IAPT services were more likely to respond later than those who
16 did not ($p=0.007$). There was also some weak evidence that NHS employees responded later
17 than private therapists, or those who worked both in the NHS and privately ($p=0.056$). There
18 was no difference in terms of timing of response by age, gender, professional background, or
19 years practising as a therapist (all $p>0.57$).
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27 **[INSERT TABLE 1 HERE]**
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29 *Frequency of material use*

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32 Therapists indicated how frequently they used each of 17 materials to support one-to-one
33 CBT with their last three clients with depression (Table 2). Frequency of use varied greatly
34 between the materials listed. Six of the materials were used ‘frequently’ or ‘very frequently’
35 by 85-90% of respondents. These were: symptom measures (89%), providing lists of
36 problems and goals (85%), activity schedules (85%), behavioural activation diary/plan
37 (85%); and case formulation (85%). The least frequently used were relaxation materials,
38 books/workbooks, sleep diaries, and computerised CBT/online materials. These were used
39 ‘frequently/very frequently’ by 39%, 33%, 22%, and 8% of therapists respectively. Indeed,
40 53% reported ‘never’ using cCBT or online materials to support CBT, and a further 22%
41 ‘rarely’ used cCBT/online materials. .
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55 In sensitivity analyses to examine whether there were differences in the frequency of
56 use of the 17 listed materials amongst therapists who responded to earlier or later invitations,
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3 there was little evidence of an association between timing of response and reported frequency
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5 of use of materials to support CBT.
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8 **[INSERT TABLE 2 HERE]**
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10 *Therapist characteristics and frequency of material use*

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12 Exploratory logistic regression analyses were conducted to examine the independent
13
14 associations between seven therapist characteristics and frequency of use of the 17 resources.
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18 There were no therapist characteristics that were consistently independently associated with
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20 more/less frequent use of the different resources (data available from authors).
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23 *Timing of material use*

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26 Therapists indicated whether they gave the listed materials to clients for use between, or
27
28 during the therapy session. Materials were most likely to be used both within and between
29
30 sessions (Table 3). There were a few exceptions – therapists predominantly used written
31
32 agendas, case formulation and problem lists exclusively within the session (86%, 57% and
33
34 53% of therapists respectively), while computerised CBT and online materials were mostly
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36 used to support CBT between sessions (62%).
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42 **[INSERT TABLE 3 HERE]**
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44 *Effectiveness of CBT materials*

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46 Therapists rated the effectiveness of the CBT materials in bringing about clinically helpful
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48 change, on a scale of 1 (not at all effective), to 9 (very effective) (Table 4). All the resources
49
50 were considered at least moderately effective (median score ≥ 5), but some were rated more
51
52 highly than others (Table 4). The resources viewed as the most effective (with a median score
53
54 of 8) were: activity schedules, behavioural activation diary/plan, case formulation, thought
55
56 records, and resources to support the identification of conditional beliefs. On the other hand,
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3 symptom measures, sleep diaries, and computerised CBT/online materials were rated as less
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5 effective (median score 5) by therapists.
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7
8 There were some associations between frequency of use and effectiveness
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10 ratings. Materials that were most frequently used (e.g. lists of problems/goals, activity
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12 schedules, behavioural activation diaries/plans, and case formulation worksheets) were also
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14 generally considered effective (median score was 7 or 8). In contrast, the use of symptom
15
16 measures (the most frequently used resource) was considered one of the least effective tools.
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18

19 **[INSERT TABLE 4 HERE]**
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21 In sensitivity analyses, there was again no evidence of an association between
22
23 timing of response and resource effectiveness ratings of materials for the 16 of the 17
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25 resources ($p > 0.12$).
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27

28 *Therapist characteristics and effectiveness ratings*

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30 Multiple linear regression was used to examine the associations between therapist
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32 characteristics and their views on the effectiveness of the 17 listed resources. Female gender
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34 was independently associated with higher effectiveness ratings for 9 out of the 17 resources
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36 (p-values for gender in the final models were all < 0.07). There were no other consistent
37
38 patterns to suggest that therapist characteristics were independently associated with
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40 effectiveness ratings (data available from the authors).
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47 *Other resources used*

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49 Therapists were asked to list the books, computerised CBT, or online materials they used to
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51 supplement their one-to-one work with their last three clients with depression. Of the 818
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53 respondents, 717 (88%) provided details of at least one resource in response to this question.
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56 Where resources were listed, participants detailed between 1 and 10 items, with a modal
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3 response of 3 resources. Resources named by more than 1% of respondents are listed in Table
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6 5.

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8 Websites that provided online resources (such as client worksheets) for therapists
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10 were very frequently cited, with the “Get Self Help” (<https://www.getselfhelp.co.uk>), “Centre
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12 for Clinical Interventions” (<http://www.cci.health.wa.gov.au>), and “Psychology Tools”
13
14 (<https://psychologytools.com>) websites being the most popular – these had been used by
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16 47%, 30% and 21% of the 717 respondents respectively.

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19 The most frequently cited books were Mind Over Mood (Greenberger & Padesky,
20
21 2015) (30%), and Overcoming Depression (Gilbert, 2009b) (11%), with a further 10% listing
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23 ‘Overcoming Depression’ without any reference to the author. Overcoming Low Self-Esteem
24
25 (Fennell, 1999) was cited by 10%, and the ‘Overcoming series’ of books in general by a
26
27 further 9%. A small proportion of therapists mentioned various computerised CBT packages
28
29 e.g. “Living Life to the Full” (<http://www.llttf.com>), (7%); “MoodGYM”
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31 (<https://moodgym.anu.edu.au>), (4%); and “Beating the Blues” (www.beatingtheblues.co.uk),
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33 (4%).
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38 Participants listed a diverse range of other tools/media that they used in their practice
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40 with depressed clients. Worksheets were the most frequently mentioned and these included
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42 thought records, progress monitoring sheets, goal setting records, and self-compassion
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44 worksheets. Therapists also used various types of diaries. Technology such as videos
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46 (including YouTube), CDs/audio recordings (for relaxation, mindfulness etc.), and mobile
47
48 applications (apps) were also listed.
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51
52 Finally, in relation to psychotherapeutic approaches used, some therapists had applied
53
54 so-called Third Wave therapies to treat recent patients including: Mindfulness, Compassion
55
56 Focused Therapy, Acceptance and Commitment Therapy, and Dialectical Behaviour
57
58 Therapy.
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60

[INSERT TABLE 5 HERE]

Discussion

CBT is delivered in a manner that is flexible and responsive to the client's needs. As such, it is perhaps unsurprising that therapists employed a broad range of materials to support one-to-one CBT for depression. However, frequency of use varied greatly between the materials listed.

The most frequently used resources (symptom measures, providing lists of problems and goals, activity schedules, behavioural activation tools; and case formulation) align with core competencies for CBT for depression (Roth & Pilning, 2007). With the exception of symptom measures, these frequently used resources were also considered some of the most effective. However, despite being the most frequently used tool, symptom measures such as the PHQ-9 were in fact considered one of the least effective tools for bringing about clinically helpful change. Frequent use of symptom measures such as the PHQ-9 was not unexpected given that the majority of respondents worked within IAPT services where such measures are a mandatory part of initial assessments and outcome reporting.

In contrast, relaxation materials, sleep diaries, books/workbooks and computerised CBT/online materials were used the least. This may reflect the fact that such materials are often delivered as low-intensity interventions (step 2) within IAPT services and therefore those clients who receive high-intensity therapy are less likely to be offered something similar to the help they may have already received. Free CBT resources on websites such as "Get Self Help", the "Centre for Clinical Interventions" and "Psychology Tools" were often cited (for example, thought records, activity schedules, psychoeducational materials) by therapists.

Most of the CBT materials used by therapists were employed both within and between therapy sessions. For instance, between 64-86% of respondents used materials to

1
2
3 support behaviour change and cognitive restructuring in this way. It is possible that materials
4
5 (e.g. thought records and activity diaries) were introduced within the session for patients to
6
7 complete at home, and reviewed at the next session. In contrast, cCBT and other online
8
9 materials were predominantly used only between sessions.
10
11

12 *Strengths and limitations*

14 In total, 1027 therapists from a wide-range of backgrounds completed the survey. We
15
16 recruited 818 accredited, high-intensity, therapists. These participants were mostly
17
18 experienced practitioners, and the majority worked within the NHS, providing IAPT services.
19
20

21
22 The recruitment strategy was comprehensive and included personalised invitations to
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24 BABCP members who were willing to be contacted about research, as well as survey
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26 promotion at BABCP conferences and via IAPT service leads. However, as only 3665 out of
27
28 ~4600 accredited members were willing to be contacted directly, this does introduce potential
29
30 for bias. The overall response rate to personalised invites was 27%, which, despite several
31
32 reminders, was somewhat lower than for previous, much smaller (n ranging 254-329)
33
34 BABCP surveys conducted between 1999-2005 (Keeley et al., 2002; MacLeod et al., 2008;
35
36 Whitfield & Williams, 2014), where response rates ranged from 53-66%. It is possible that
37
38 some members have become survey-fatigued due to repeated requests for their feedback, or
39
40 have become uncontactable since registering their details with BABCP. We found that
41
42 members were more likely to respond to postal invites than email requests (34% versus 12%
43
44 respectively), and this may reflect members' reluctance to respond to unsolicited survey
45
46 requests sent by email.
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51 It is possible that those who did not use CBT resources, or found them ineffective,
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53 were less likely to respond. However, our sensitivity analysis showed no evidence of
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55 differences in resource use, or ratings of effectiveness between those who responded to the
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57 first invitation, or later reminders. We found that those working in IAPT services tended to
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3 reply later and thus it is possible that the views of these therapists were underrepresented. The
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5 proportion of female respondents reflected the gender balance of the full sample of invitees,
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7 but we were unable to assess the representativeness of other therapist characteristics.
8
9 However, therapist characteristics were not associated with frequency of resource use or
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11 views on effectiveness.
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13

14
15 As with other self-report measures, participants' responses may be affected by other
16
17 biases including acquiescence bias. Views on effectiveness may also be influenced by a
18
19 therapist's training and knowledge of CBT, as well as their own clinical experience.
20
21 Importantly, when describing resources, we used terminology that would be familiar to
22
23 accredited CBT therapists – based on treatment manuals and key CBT resources for
24
25 practitioners. To our knowledge, this is the largest survey of UK therapists to date and,
26
27 provides valuable data about the resources that therapists use during therapy and their views
28
29 on effectiveness.
30
31

32 33 *Comparison with previous studies*

34
35 A previous survey of UK accredited therapists' views of structured self-help materials
36
37 (Keeley et al., 2002) showed that most therapists recommended self-help resources,
38
39 particularly for the treatment of depression, and most commonly to supplement individual
40
41 therapy. While Keeley's survey focused on self-help materials, and our survey relates to CBT
42
43 resources more generally, there are some noteworthy similarities. Our survey showed
44
45 numerous self-help materials are currently recommended, with Mind Over Mood
46
47 (Greenberger & Padesky) being the most frequently cited book; this aligns with Keeley's
48
49 findings 18 years previously.
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51

52
53 Our findings suggest that the proportion of therapists recommending computerised
54
55 resources has increased. Keeley et al. (2002) reported that most recommended materials were
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57 in written form, with only 7% of self-help prescribing therapists reporting use of
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1
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3 computerised delivery. A similar practitioner survey conducted in 2001 (Whitfield &
4
5 Williams) suggested that only 2% used computer-based self-help treatment for mental illness
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7 with their clients, with barriers including lack of training, personal knowledge and research
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9 regarding cCBT, as well as financial and practical constraints. While relatively few of our
10
11 respondents reported frequent use of computerised materials to support one-to-one therapy
12
13 for depression, we found that 24% had used these at least 'sometimes'. This increase could be
14
15 explained by the availability of research evidence into the effectiveness of cCBT, NICE
16
17 guidelines (National Collaborating Centre for Mental Health, 2010) and increased provision
18
19 of computerised therapy as part of low-intensity psychological services.
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23

24 *Clinical implications*

25
26 There continues to be a substantial gap between provision of, and demand for, psychological
27
28 treatment. Technological innovations could potentially revolutionize mental health care and
29
30 enable, rather than just support its delivery (Mohr et al., 2017), for example by enabling
31
32 treatments to be delivered in a way that increases uptake and adherence to therapy. Previous
33
34 qualitative research has highlighted the challenges of undertaking 'homework' tasks
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36 including getting 'caught' writing thoughts and feelings down on paper, or having to wait
37
38 until the evening to recall earlier thoughts (Barnes, M et al., 2013). Mobile phone apps and
39
40 online platforms have potential to allow discrete and more immediate completion of such
41
42 tasks. Enabling greater engagement with therapy through completion of homework is
43
44 important as this has been shown to improve outcomes (Kazantzis et al., 2010; Mausbach et
45
46 al., 2010; Thase & Callan, 2006). CBT interventions that include remotely-delivered, online
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48 elements could also improve adherence for those who find attending face-to-face
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50 appointments difficult or inconvenient.
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56 The evidence from our survey on therapists' use of, and views on the effectiveness of,
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58 CBT resources will be important for the development of novel approaches which employ
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3 technology to enhance and enable the delivery of CBT. For example, these findings have
4
5 implications for the design of integrated CBT platforms. Our data suggest that such systems
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7 should incorporate a range of resources from familiar sources and be designed to allow
8
9 flexibility of use, with online resources accessible to patients and therapists to view and edit,
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11 both within and between the therapy sessions. This will enable therapists to tailor CBT
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13 delivered online to individual patient's needs, as they do in face-to-face therapy.
14
15

16 17 **Conclusion**

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19 This large practitioner survey provided evidence on therapists' use of materials to support
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21 one-to-one CBT for depression, and therapists' perceived effectiveness of such resources in
22
23 bringing about clinically helpful change. Understanding more about the materials that
24
25 therapists use as an integral part of their work is important in the development of
26
27 "technology-enabled" psychological services that may address the increasing demand for
28
29 access to psychological services. Ensuring that online platforms incorporate a range of
30
31 materials to enable therapists to tailor treatment to the individual patient's needs is key. Such
32
33 platforms also need to be designed with input from experts in human-computer interaction to
34
35 maximise engagement with, and thus ultimately benefit from, treatment. In this way, we may
36
37 be able increase access to treatment by enabling therapy for those who find attending face-to-
38
39 face sessions difficult, and by facilitating homework completion. This could potentially
40
41 improve patient outcomes for the large number of patients with depression.
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Ethical statements

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, and its most recent revision. Authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the American Psychological Association. Ethical approval was provided by *[name of REC anonymised]* Research Ethics Committee (29/2/2016; *REC reference anonymised*). HRA approval was also granted (8/3/2016; *IRAS reference anonymised*).

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[Name of author] is author of written and online CBT self-help resources, and is Director of a company which commercialises these resources. The other authors have no conflict of interests with respect to this publication.

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Table 1: Characteristics of participants

Characteristic	No. responses	N (%) or Mean (SD)
Gender	818	
Male		200 (24.4)
Female		618 (75.6)
Age (in years)	812	46.9 (10.0)
Professional background*	816	
Nurse		273 (33.5)
Counsellor/Counselling Psychologist		135 (16.5)
CBT Therapist		120 (14.7)
Clinical psychologist		75 (9.2)
Occupational Therapist		54 (6.6)
Social Worker		42 (5.2)
Psychological Wellbeing Practitioner/Mental Health Worker		28 (3.4)
Psychotherapist		28 (3.4)
Psychologist (other)		22 (2.7)
Psychiatrist		11 (1.4)
Other		28 (3.4)
Years practicing as CBT therapist	815	9.3 (6.1)

Work within IAPT service	812
Yes	505 (62.2)
No	307 (37.8)
Supervisor	817
Yes	570 (69.9)
No	245 (30.1)
Work setting	812
NHS	470 (57.9)
Private practice	122 (15.0)
Both	220 (27.1)

*our questionnaire only included 6 response options for Professional background (Nurse/Counsellor/Clinical Psychologist/Occupational Therapist/Psychiatrist/Other). However, 320 individuals selected 'other' and described their background. These were recoded into new or existing categories where possible.

Table 2: Frequency of use of materials to support one-to-one CBT for depression

CBT material	How often did you use these materials?											
	Total		Never		Rarely		Sometimes		Frequently		Very frequently	
	N	n	% (95%CI)	n	% (95%CI)	n	% (95%CI)	n	% (95%CI)	n	% (95%CI)	
Materials to support behavioural change												
Activity schedules	811	4	0.5 (0.1, 1.3)	12	1.5 (0.8, 2.6)	107	13.2 (10.9, 15.7)	299	36.9 (33.5, 40.3)	389	48.0 (44.5, 51.5)	
Behavioural activation diary/plan	796	9	1.1 (0.5, 2.1)	14	1.8 (1.0, 2.9)	94	11.8 (9.6, 14.3)	293	36.8 (33.5, 40.3)	386	48.5 (45.0, 52.0)	
Written resources to support planned exposure	813	44	5.4 (4.0, 7.2)	86	10.6 (8.5, 12.9)	229	28.2 (25.1, 31.4)	253	31.1 (27.9, 34.4)	201	24.7 (21.8, 27.8)	
Behavioural experiments relating to depressive beliefs	809	40	4.9 (3.6, 6.7)	82	10.1 (8.1, 12.4)	236	29.2 (26.1, 32.4)	266	32.9 (29.6, 36.2)	185	22.9 (20.0, 25.9)	
Materials to support cognitive restructuring/change												
Mood diary	810	38	4.7 (3.3, 6.4)	64	7.9 (6.1, 10.0)	174	21.5 (18.7, 24.5)	240	29.6 (26.5, 32.9)	294	36.3 (33.0, 39.7)	
Thought record	816	18	2.2 (1.3, 3.5)	23	2.8 (1.8, 4.2)	112	13.7 (11.4, 16.3)	250	30.6 (27.5, 33.9)	413	50.6 (47.1, 54.1)	

30

CBT material	How often did you use these materials?										
	Total	Never	Rarely	Sometimes	Frequently	Very frequently					
Other materials											
Symptom measures e.g. PHQ-9	815	23	2.8 (1.8, 4.2)	21	2.6 (1.6, 3.9)	42	5.2 (3.7, 6.9)	100	12.3 (10.1, 14.7)	629	77.2 (74.1, 80.0)
Providing a list of problems/goals	814	20	2.5 (1.5, 3.8)	22	2.7 (1.7, 4.1)	81	10.0 (8.0, 12.2)	240	29.5 (26.4, 32.7)	451	55.4 (51.2, 58.9)
Creating a written agenda	809	36	4.4 (3.1, 6.1)	72	8.9 (7.0, 11.1)	139	17.2 (14.6, 20.0)	174	21.5 (18.7, 24.5)	388	48.0 (44.5, 51.5)
Written or diagrammatic resources to support identification of unhelpful thinking	814	15	1.8 (1.0, 3.0)	23	2.8 (1.8, 4.2)	95	11.7 (9.5, 14.1)	235	28.9 (25.8, 32.1)	446	54.8 (51.3, 58.2)
Resources to support practical problem solving	814	36	4.4 (3.1, 6.1)	88	10.8 (8.8, 13.1)	287	35.3 (32.0, 38.7)	220	27.0 (24.0, 30.2)	183	22.5 (19.7, 25.5)
Case formulation, case summary or case conceptualisation worksheet	814	14	1.7 (0.9, 2.9)	26	3.2 (2.1, 4.6)	83	10.2 (8.2, 12.5)	239	29.4 (26.3, 32.6)	452	55.3 (52.0, 59.0)
Written or diagrammatic resources to support the identification of conditional	811	31	3.8 (2.6, 5.4)	63	7.8 (6.0, 9.8)	197	24.3 (21.4, 27.4)	265	32.7 (29.5, 36.0)	255	31.4 (28.3, 34.8)

31

CBT material	How often did you use these materials?											
	Total	Never	Rarely	Sometimes	Frequently	Very frequently						
beliefs / underlying assumptions / 'rules for living'												
Relaxation materials	813	108	13.3 (11.0, 15.8)	142	17.5 (14.9, 20.3)	244	30.0 (26.9, 33.3)	185	22.8 (19.9, 25.8)	134	16.5 (14.0, 19.2)	
Sleep diary	810	119	14.7 (12.3, 17.3)	175	21.6 (18.8, 24.6)	336	41.5 (38.1, 45.0)	125	15.4 (13.0, 18.1)	55	6.8 (5.2, 8.7)	
Book and workbooks	811	129	15.9 (13.5, 18.6)	172	21.2 (18.4, 24.2)	246	30.3 (27.2, 33.6)	150	18.5 (15.9, 21.3)	114	14.1 (11.7, 16.6)	
Computerised CBT and online materials	811	433	53.4 (49.9, 56.9)	181	22.3 (19.5, 25.3)	132	16.3 (13.8, 19.0)	39	4.8 (3.4, 6.5)	26	3.2 (2.1, 4.7)	

Table 3: Timing of use of materials to support one-to-one CBT for depression

CBT material	No. responses	When did you use these materials?					
		Between sessions		During sessions		Both	
		n	% (95% CI)	n	(95% CI)	n	(95% CI)
Materials to support behavioural change							
Activity schedules	797	89	11.2 (9.1, 13.6)	90	11.3 (9.2, 13.7)	618	77.5 (74.5, 80.4)
Behavioural activation diary/plan	780	62	8.0 (6.1, 10.1)	73	9.4 (7.4, 11.6)	645	82.7 (79.9, 85.3)
Written resources to support planned exposure	732	117	16.0 (13.4, 18.8)	145	19.8 (17.0, 22.9)	470	64.2 (60.6, 67.7)
Behavioural experiments relating to depressive beliefs	746	90	12.1 (9.8, 14.6)	126	16.9 (14.3, 19.8)	530	71.1 (67.6, 74.3)
Materials to support cognitive restructuring/change							
Mood diary	745	142	19.1 (16.3, 22.1)	58	7.8 (6.0, 9.9)	545	73.2 (69.8, 76.3)
Thought record	789	47	6.0 (4.4, 7.8)	60	7.6 (5.9, 9.7)	682	86.4 (83.8, 88.8)
Other Materials							
Symptom measures e.g. PHQ-9	786	126	16.0 (13.5, 18.8)	356	45.3 (41.8, 48.8)	304	38.7 (35.3, 42.2)
Providing a list of problems/goals	776	26	3.4 (2.2, 4.9)	413	53.2 (49.6, 56.8)	337	43.4 (40.0, 47.0)

CBT material	When did you use these materials?						
	No. responses	Between sessions		During sessions		Both	
		n	% (95% CI)	n	(95% CI)	n	(95% CI)
Creating a written agenda	740	15	2.0 (1.1, 3.3)	634	85.7 (83.0, 88.1)	91	12.3 (10.0, 14.9)
Written or diagrammatic resources to support identification of unhelpful thinking	792	30	3.8 (2.6, 5.4)	182	23.0 (20.1, 26.1)	580	73.2 (70.0, 76.3)
Resources to support practical problem solving	763	48	6.3 (4.7, 8.3)	229	30.0 (26.8, 33.4)	486	63.7 (60.2, 67.1)
Case formulation, case summary or case conceptualisation worksheet	788	7	0.9 (0.4, 1.8)	449	57.0 (53.4, 60.5)	332	42.1 (38.7, 45.7)
Written or diagrammatic resources to support the identification of conditional beliefs / underlying assumptions / 'rules for living'	763	26	3.4 (2.2, 5.0)	373	48.9 (45.3, 52.5)	364	47.7 (44.1, 51.3)
Relaxation materials	688	194	28.2 (24.9, 31.7)	71	10.3 (8.1, 12.8)	423	61.5 (57.8, 65.1)
Sleep diary	665	235	35.3 (31.7, 39.1)	54	8.1 (6.2, 10.5)	376	56.6 (52.3, 60.3)
Book and workbooks	654	262	40.1 (36.3, 43.9)	55	8.4 (6.4, 10.8)	337	51.5 (47.6, 55.4)
Computerised CBT and online materials	343	214	62.4 (57.0, 67.5)	29	8.5 (5.7, 11.9)	100	29.3 (24.4, 34.3)

Table 4: Therapists' views on the effectiveness of materials in bringing about clinically helpful change

CBT Material	Total responses N	Median (IQR)
Materials to support behavioural change		
Activity schedules	810	8 (7, 8)
Behavioural activation diary/plan	809	8 (7, 9)
Written resources to support planned exposure	806	7 (5, 8)
Behavioural experiments relating to depressive beliefs	805	7 (6, 8)
Materials to support cognitive restructuring/change		
Mood diary	808	7 (5, 8)
Thought record	809	8 (7, 9)
Other Materials		
Symptom measures e.g. PHQ-9	795	5 (4, 7)
Providing a list of problems/goals	807	7 (6, 8)
Creating a written agenda	807	6 (5, 8)
Written or diagrammatic resources to support identification of unhelpful thinking	806	8 (6, 9)
Resources to support practical problem solving	804	7 (5, 8)
Case formulation, case summary or case conceptualisation worksheet	806	8 (7, 9)

CBT Material	Total responses N	Median (IQR)
Written or diagrammatic resources to support the identification of conditional beliefs / underlying assumptions / 'rules for living'	804	7 (6, 8)
Relaxation materials	796	6 (4, 7)
Sleep diary	796	5 (4, 7)
Books and workbooks	785	6 (5, 7)
Computerised CBT and online materials	716	5 (3, 6)

^a1=Not at all effective; 5=Moderately effective; 9=Very Effective

Table 5: Other books/computerised CBT/online materials used^a

CBT Material	Reference	N	%^b
“Get Self Help”	https://www.getselfhelp.co.uk	334	46.6
“Centre for Clinical Interventions”	http://www.cci.health.wa.gov.au	215	30.0
Mind Over Mood	Greenberger & Padesky (2015)	215	30.0
“Psychology Tools”	https://psychologytools.com	151	21.0
Overcoming Depression	Gilbert (2009b)	77	10.7
Overcoming Depression (Author not specified) ^c		72	9.9
Overcoming Low Self Esteem	Fennell (1999)	68	9.5
The Overcoming series of books ^d		62	8.6
Compassionate Mind ^e	Gilbert (2009a)	60	8.4
“Living Life to the Full”	http://www.llttf.com	51	7.1
Five Areas resources	C. Williams (2014, 2017)	46	6.4
Northumberland, Tyne & Wear NHS Foundation Trust materials		43	6.0
“Moodgym”	https://moodgym.anu.edu.au	31	4.3
Overcoming Depression One Step at a Time	Addis & Martell (2004)	29	4.0

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3	“Headspace”	https://www.headspace.com	28	3.9
4				
5	Black Dog resources		28	3.9
6				
7				
8	The Mindful Way Through Depression	M. Williams, Teasdale, Segal, & Kabat-Zin (2007)	28	3.9
9				
10	Mindfulness: Finding Peace in a Frantic World ^f	M. Williams & Penman (2011)	27	3.8
11				
12	Beating the Blues	www.beatingtheblues.co.uk	26	3.6
13				
14	“SilverCloud”	http://www.silvercloudhealth.com	20	2.8
15				
16				
17	Behavioral Activation for Depression	Martell, Dimidjian, & Herman-Dunn (2010)	19	2.6
18				
19	Feeling Good Handbook	Burns (1999)	18	2.5
20				
21				
22	Treatment Plans and Interventions for Depression and Anxiety Disorders	Leahy, Holland, & McGinn (2011)	18	2.5
23				
24	The Happiness Trap	R. Harris (2008)	17	2.4
25				
26	The Mental Health Handbook	Powell (2009)	17	2.4
27				
28	“Moodjuice”	www.moodjuice.scot.nhs.uk	16	2.2
29				
30				
31	An Introduction to Coping with Depression	Brosnan & Hogan (2007)	15	2.1
32				
33	Manage Your Mood	Veale & Willson (2007)	15	2.1
34				
35	CBT for Dummies	Branch & Willson (2010)	14	2.0
36				
37				
38	Think Good Feel Good	Stallard (2002)	12	1.7
39				
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1	Compassionate Mind Approach to series ^g		12	1.7
2				
3	Manage Your Mind	A. Butler & Hope (2007)	11	1.5
4				
5	Cognitive Therapy of Depression	Beck, Rush, Shaw, & Emery (1979)	11	1.5
6				
7	Depressive Illness: the Curse of the Strong	Cantopher (2012)	9	1.3
8				
9	“Big White Wall”	https://www.bigwhitewall.com	8	1.1
10				
11	Psychology Online (now Ieso Digital Health)	https://www.iesohealth.com/en-gb	8	1.1
12				
13				
14				
15				
16				
17				
18				
19	Generic resources/approaches (not otherwise specified)			
20				
21	Mindfulness		40	5.6
22				
23	Acceptance and Commitment Therapy (ACT)		15	2.1
24				
25	Behavioural activation (BA)		14	2.0
26				
27	Compassion-Focused Therapy (CFT)		14	2.0
28				
29	Beck		12	1.7
30				
31				
32				
33				
34				
35				

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2
3^a Therapists were asked to ‘list the books and/or computerised CBT/online materials that you used to supplement your one-to-one work with
4
5 your last 3 clients with depression’. Participants could report more than one additional resource used to support their practice
6
7

8^b As a percentage of the 717 participants who listed at least one resource.
9

10
11^c Where ‘Overcoming Depression’ was cited without reference to the author, this could potentially include ‘Overcoming Depression’ (Gilbert,
12
13 2009b), Overcoming Depression and Low Mood: a Five Areas Approach (C. Williams, 2014), or Overcoming Depression One Step at a Time
14
15 (Addis & Martell, 2004).
16
17

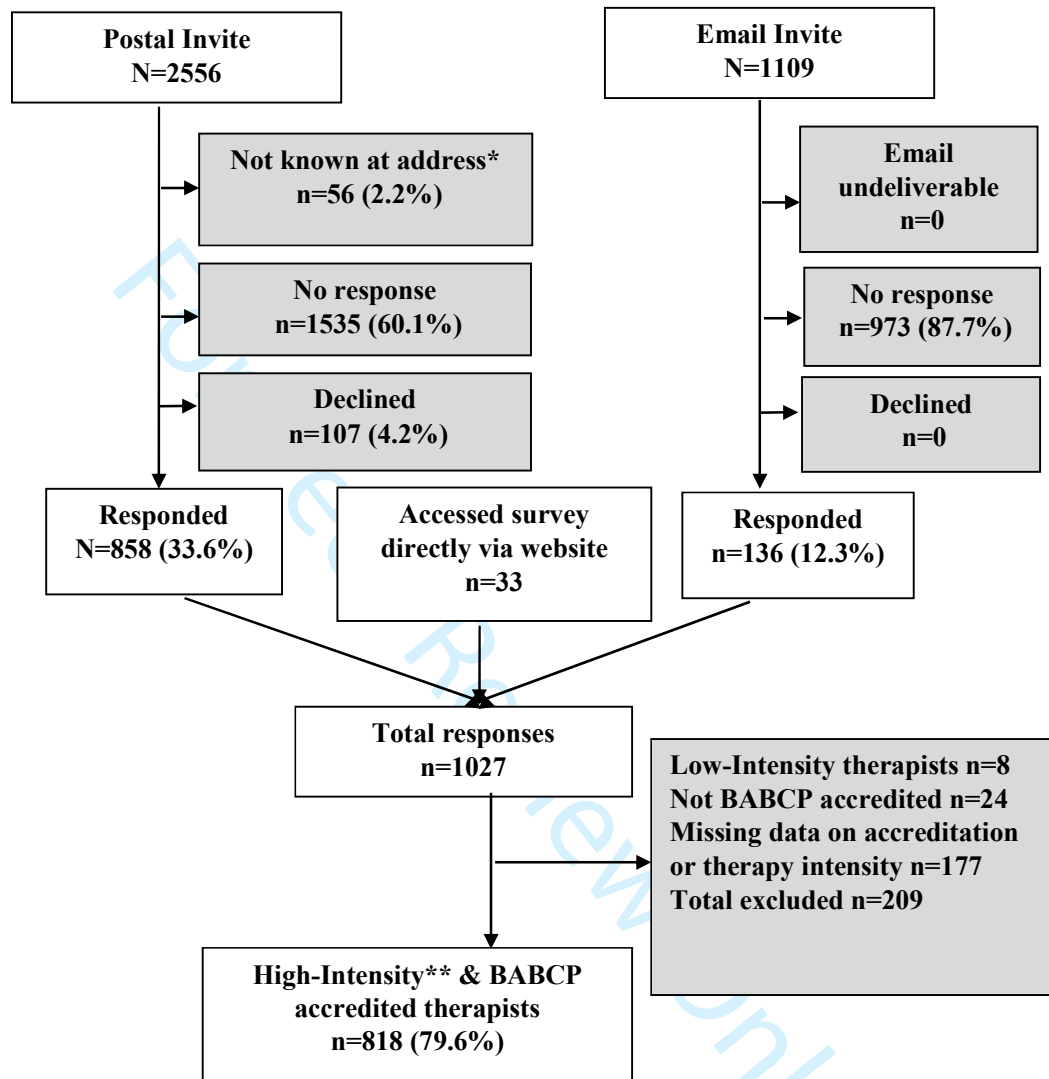
18
19^d Some therapists listed ‘other Overcoming books’, or ‘Overcoming series of books’
20
21

22^e Including Compassionate Mind Foundation (Gilbert), Compassionate Mind formulations/online resources, ‘Compassionate Mind’, Compassion
23
24 Focussed Therapy (Gilbert), Compassion-focussed (Gilbert), and Mindful Compassion (Gilbert; Gilbert & Choden, 2015)
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26

27^f Including ‘Mindfulness – Williams’
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30^g Compassionate Mind Approach to Building Your Self-Confidence (Welford, 2012); The Compassionate Mind Guide to Recovering from
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32 Trauma and PTSD (Lee & James, 2013), or ‘Compassionate Mind Guide to series’
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Figure 1: Flow diagram of therapist recruitment



*these individuals were subsequently emailed the invite where possible

**deliver High-Intensity Therapy only, or both High and Low-Intensity Therapy